Women &
HEALTH

Action on Issues

WOMEN & HEALTH

Presented by the Ontario Advisory Council on Women's Issues
Spring 1988

90-06579/

The Ontario Advisory Council on Women's Issues was established in 1973 by Order-In-Council.

Council's mandate is to advise Ontario's government on matters pertaining to women through the Minister Responsible for Women's Issues; to monitor and assess existing legislation, policies and programs for women; to identify specific areas for the government's attention and recommend legislation and program changes; to meet with women's groups throughout Ontario and hold public forums; to advise and consult with the Minister Responsible for Women's Issues.

There are 15 members, including a President and Vice-President, all of whom are appointed by Cabinet on a part-time basis for three-year terms.

The Ontario Advisory Council on Women's Issues
880 Bay St., 5th floor
Toronto, Ontario M7A 1N3
(416) 965-5824 (call collect)

Writer:

Lindsay DuBois is a PhD student in social anthropology at the New School for Social Research in New York. In her three years with the Ontario Advisory Council on Women's Issues, Lindsay worked on women's health issues. She also acted as researcher and conference coordinator, organizing the Women and Health conference in March 1985.

Cartoonist:

Susan Dewar is the political cartoonist for the *Calgary Sun*. Her cartoon, *Downhill*, appears daily in the *Toronto Sun*.

Designer:

Andrea Johnston is a freelance graphic designer in Toronto. Her responsibilities with Ontario Advisory Council on Women's Issues include design and production co-ordination of publications.

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1 PART ONE

Introduction

What this Booklet is About

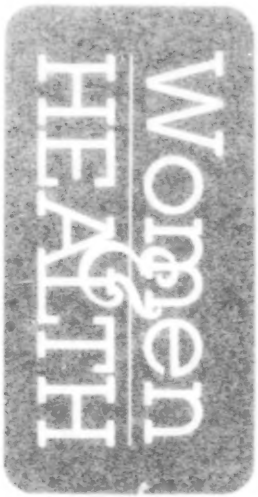
You probably opened this booklet because you are interested in women and health. Perhaps you want to learn something more about your health. Maybe you are trying to make sense of the sometimes complicated and confusing world of hospitals, clinics and doctors' offices. Maybe you have a concern of your own that you would like to raise, and you want to know what you can do about it. This booklet is designed for you. It has a number of different sections: this introduction, a look at *some* of the major themes dealing with women's health, some information about how you and your family can best use the health care system, and a look at the different kinds of action you can take. In case you want to find out more, we have also included a list of some resources for further information starting on page 43. Technical terms used throughout this publication are defined in the Glossary starting on page 38.

Why WOMEN'S Health?

One of the first questions people ask about women's health is: "Why *women*? Why not people's health"? It's true that women's issues are people's issues in that they concern our whole society. But women are by default the main users of the health care system because we use it for ourselves and our families. We are also the main providers of health care – as nurses, doctors, health care workers and providers of care in the home –

and we tend to feel very strongly about health issues. And, like other women's issues, an interest in women's health has arisen to address a gap. Women have found that their experience of the health care system is different from men's. They are being treated differently (often they don't like the way they are being treated!), and they are concerned about issues that aren't getting raised and discussed elsewhere. They believe it is important to see women's health in the context of women's position in society. In our present society, women and men have different biological and social roles, which affect their health in special ways. "Women's health issues" have arisen to address this varied set of concerns and problems.

The Women and Health Conference



In March 1985, the Ontario Advisory Council on Women's Issues hosted a public conference on women and health. Women and men from across the province attended. Health professionals, health activists, civil servants and other interested people came together to share and exchange their views on women's health in Ontario and what the government's role should be. After the conference, Council published the proceedings and a list of recommendations to the government. (These documents are available from Council. See Resources section for details).

But Council didn't want to leave the matter there; this booklet is another part of that project. It is meant as a general introduction to the issues, and will suggest ways women can better voice their personal and social concerns about health.

Health Care is a Social Concern...

In our society, most of us are used to associating health care with women and men in white coats, with labs, antiseptic corridors and expensive complicated technology. But health care is more than just medicine. We know that good health is an essential part of a good life. Perhaps you have heard people saying "at least I've got my health..." and we should recognize health as a basic right, not a luxury.

Although we are fortunate to have high quality public health care in Canada, our health care system is far from perfect. One of its major flaws is that some patients receive better care than others. Women, and especially disadvantaged women (visible minority, immigrant, poor, and disabled women, for example) are often among those who get lower quality care.

Social inequalities can create health problems. Poverty, homelessness and stress are powerful factors affecting the health of Ontarians. The inequality between the sexes in our society means that women are more likely than men to suffer from these social health hazards.

The fact that those with more advantage in our society can usually get exactly what they want while others go without is against the very principle of public health care. Although Ontario's is one of the best health care systems in the world, we need to change it, to make it even better and more just, so that we can take pride in it without reservation.

...But it Costs a lot of Money

Public health care is expensive. It has to compete with other public services for our tax dollars. One of the most important issues in health care is the allocation of that money: how much the health care system gets and where it goes within the system. The questions of where the money goes is becoming more complex all the time. Each day medical technology (transplants and artificial organs, for example) becomes more expensive. At the same time, more and more malpractice lawsuits against doctors raise the cost of health care even higher (see "Medical Malpractice", page 5).

"We are confronted with questions of weighing dollars against health and even . . . lives."

The question of money becomes a moral and political one. We are confronted with questions of weighing dollars against health and even – as upsetting as the notion may be – lives.

For example, should we regularly use expensive cancer screening procedures? What if the money spent on these could be used elsewhere, on less costly and less dramatic services: health promotion and education for example? Can we afford to give everyone the best possible health care (like artificial organs)? On the other hand, can we permit a two-tiered system – where the rich can buy these very expensive procedures, while the poor cannot? Must we treat everyone equally? If we decide that some procedures are too expensive for public funds, must we also deny them to those who can pay? Clearly, issues about dollars and cents raise very important moral and social concerns. We can't afford to leave decisions that affect us so deeply only to politicians and "experts". We must participate in the debates ourselves.

Medical malpractice is a complicated issue bringing together concerns about money, protection of rights, and responsibility. The existence of malpractice law suits helps to protect the public. It allows us to hold people (in this case, generally doctors and hospitals) responsible when they make mistakes. This is particularly important for the victims of these mistakes, as well as for encouraging quality care and discouraging sloppiness.

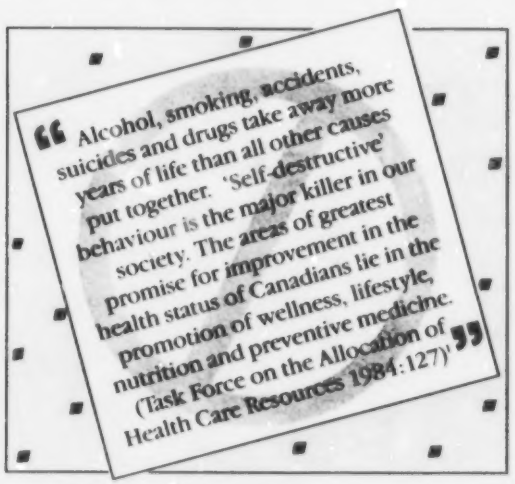
However, the increasing tendency for people to sue, the higher legal costs of fighting law suits, the fact that people are winning more often, and winning the bigger awards, all combine to cost the system a lot of money. For example, the amount a Canadian surgeon paid for liability insurance in 1986 was almost twice that paid in 1985. Meanwhile, hospitals' insurance bills went up by almost ten times in the year between 1985 and 1986 (Surgeon's Update 1986:85). Because the health care system is public, we are the ones who end up paying these extra costs.

The increase in malpractice suits can also encourage over-testing. Doctors are likely to recommend more tests, x-rays, etc. than they believe necessary as a way of protecting themselves. These tests cost money. But what if one of those extra tests finds something important? Are the many that didn't worth their cost to the system?

Perhaps the worst possible result of the law suit problem is that some doctors may hesitate to take on certain kinds of cases for fear of a problem which might lead to a law suit. The fear of law suits is far worse in the United States where, for example, some obstetrician-gynecologists avoid delivering babies because they risk gigantic law suits if anything goes wrong.

PART TWO

Some major health issues


"Alcohol, smoking, accidents, suicides and drugs take away more years of life than all other causes put together. 'Self-destructive' behaviour is the major killer in our society. The areas of greatest promise for improvement in the health status of Canadians lie in the promotion of wellness, lifestyle, nutrition and preventive medicine. (Task Force on the Allocation of Health Care Resources 1984:127)"

"An ounce of prevention is worth a pound of cure"

"An ounce of prevention is worth a pound of cure," or so the saying goes. More and more, people are coming to understand the truth of this old saying. "Health promotion and disease prevention", as it is officially called, offers the idea that many illnesses and health problems can be prevented or treated before they become too serious. This means that if you want to be healthy, you have to be an active participant in your own health care. The most basic aspects of health promotion and disease prevention are eating properly and exercising. It seems ironic that in a country as wealthy as Canada, so many of us have poor diets. It is almost criminal that some Canadians are malnourished or starving. Women are particularly prone to problems of nourishment either because of poverty or in the interest of staying or becoming slim. (see "Eating And Not Eating," page 8). As well as its more obvious advantages – keeping people from getting sick in the first place – prevention is cheaper than major medical care. Although part of the responsibility for taking care of our health falls to us, the health care system also plays a part. Doctors, nurses, pharmacists, and dieticians for example,

[1] In this booklet, references to books and articles used will be given in the main part of the text. The style is (author year:page(s)). For example (Smith 1987:24-57) means the book or article is by Smith, published in 1987 and the information cited can be found on pages 24 through 57. If there are no pages given, as in (Smith 1987), the refernce is to the whole document. You can find the title, and other information about the source listed by author in the Bibliography section.

can give us information and advice that may help keep us out of their offices.

In our current society, women visit doctors more often than men (Statistics Canada, 1985:91). Some people think that this is because women are more likely to be hypochondriacs. The truth is that women tend to visit the doctor before health problems get out of hand, sometimes saving themselves from serious illness, and saving money too. (Hospital care is much more expensive than a few visits to the doctor!).

A cleaner and healthier environment is also vital for our health. We must tell our politicians and businessmen that an unclean environment is making us unhealthy.

Options and Choices in Health Care: A Little Knowledge Goes a Long Way

Many women are concerned about what kinds of options and choices they have in health care. Women want to have some control over the type and extent of care they receive. For example, when it comes to childbirth, some women want to have natural childbirth, others want to use anesthetics. Some women want their babies delivered by a doctor in a hospital while others want to give birth with the help of a midwife in a birthing centre or at home. A little knowledge is a good thing and will help us to have more control over our health care. With knowledge and information, people can more easily make the best choice.

It is important to remember that as patients we have special access to information about our own health: **we feel it from the inside**. This is why it is important that we ask questions about health problems and their treatments. You have **every right** to expect and demand information about what the health care provider thinks is wrong with you. You should be told about the different possible treatments, including their pros and cons (see "Some Hints for Going to the Doctor," page 10).

Given our culture's obsession with extreme thinness, eating and not eating is hard to escape. Women's magazines are full of articles on dieting, "tummy trimming," and fashions designed only for the very thin. We see images of very thin women everywhere: on TV, in magazines, at the movies, on billboards. The prejudice against obesity is still very prevalent in North America. It's easy to think that you are the only one who doesn't have a "perfect" body. (Although if you actually take a good look around you, you'll begin to see how unrealistic these images are.) Very few of us were meant to look like a model. Body weight can vary considerably (30 pounds or so) and still be perfectly healthy. The more important health factor (assuming one is not too far under or over weight) is how you *feel* about your weight. Our energy would be much better spent learning to accept how we are built than on unhealthy dieting.

Somehow fitness has gotten mixed up with the search for the "perfect" body. Instead of exercising for fun and because it makes us feel good (it's great for stress!) we are encouraged to exercise for vanity's sake.

Anorexia Nervosa and Bulimia

Anorexia nervosa and bulimia are eating disorders which represent the extreme of our obsession with dieting and eating. Nine out of ten people with eating disorders are women and about 50,000 young Canadian women between 14 and 24 are suffering from anorexia nervosa or bulimia. As many as 30 per cent of young women have periodic episodes of binge eating. Both anorexics and bulimics are unhappy with their body shape and extremely afraid of gaining weight. Gaining weight is seen as losing control. And often people

with eating disorders come to feel that their weight is the only area of their lives they can really control.

Many of the **symptoms** of eating disorders are actually caused by starvation. Studies have shown that when food is restricted and people lose weight, they experience significant psychological and physical change. Psychological changes include changes in attitudes towards food and eating (some become bulimic). Starvation can also cause increased depression, anxiety, social withdrawal, poor concentration and a reduction in sexual interest. Physical changes include hair loss, dry skin and disturbed sleep patterns.

Although it is hard to identify the **causes** of anorexia nervosa or bulimia, there are a number of factors which may lead to their development. The importance of the different factors vary from person to person. Some reasons people become anorexic or bulimic are: social and cultural (for example, the emphasis on extreme thinness mentioned above), emotional (e.g. the need for control), and family situation (for example, poor communication and over protectiveness).

The fact that so many anorexics and bulimics are women, and the attitudes these women have towards their bodies, suggest that eating disorders are at least partly social, having to do with the way women are taught to think of themselves and their bodies.

Author's Note: (This information is from **An Introduction to Eating Disorders: The Facts on Anorexia Nervosa and Bulimia**, distributed by the National Eating Disorder Information Centre (see Bibliography).

Some Hints For Going to the Doctor

1. **Feel free to bring with you, a friend, family member or someone else you trust for moral and emotional support.** When you are sick or upset, you may find explanations confusing or hard to understand. You will probably feel less intimidated if you have a friend there to back you up.

2. **Be sure to give accurate information to the health professional you are seeing.** You may want to write down the names of your medications (especially if they have long technical names!) at home and bring a list to the doctor's office. You should be sure to mention any medical problems or medication you may be taking. You never know what might be important. Don't forget over-the-counter drugs and medications.

3. **Ask questions and get answers.** Often doctors seem very busy, so we hesitate to bother them with questions, but remember that it is IMPORTANT for your health that you understand exactly what is going on. Explanations are part of the job. If your doctor seems unwilling to explain, ask her/him again, but if you still aren't happy, look for another doctor if this is possible in your area. Don't give up until you are satisfied.

You may want to **write down some questions** before you go so you don't forget them. You may also want to call back if you think of questions after you have left. The health care professional may not have the answers to all your questions at the moment you ask them, but at the very least, she/he should be able to tell you where you can find out more.

4. **What are risks and side effects?** Before you have an operation or take a drug, you should ask about possible risks and side effects: (a) to help you choose a course of treatment, (b) so that you can avoid potential problems (due to combination of drugs, for example) and, (c) so you can recognize side effects if they do occur.

5. **Think seriously about your options.** Consider how well various alternatives suit your lifestyle. Do some reading (see "Don't believe everything you read," page 32). Ask yourself whether a given treatment is one that makes sense for you. Consider the costs (things you may have to give up, side effects) and benefits (effectiveness). For birth control, for example, you will have to consider whether a method is one you will actually use properly (it's absolutely useless to you if you don't!).

6. **Feel free to seek a second opinion.** If you are not entirely comfortable with the advice a doctor is giving you, you have a right to a second opinion. Some doctors may be offended by this, but don't let that stop you! You can politely explain to your doctor that it's not that you don't trust her/him, but only that you would feel happier with a second opinion.

7. **Be Firm.** If you have made a careful, reasoned, informed decision, be willing to fight for it. Remember, *you* have to live with the consequences.

Author's Note: Mary Breen's book **Taking Care** (see Bibliography) has a good section on "Patients' Rights" pp.277-303, which is full of good advice on your rights as a patient.

More Than Just Reproductive Health

Some of the areas where women most want and need the right to have choices are: childbirth, birth control, and abortion (see page 20, and Resources section).

But problems focusing on women's reproductive systems **are not** the only health concerns women face. Although 1978 statistics show that pregnancy complications, delivery, and abortions were causes of women's hospitalization 23% of the time, more than three out of four times, women were hospitalized for *other* problems (Statistics Canada 1985:92). Most of these other illnesses are shared by men, but some might be made worse because of women's present role in our society.

Social Concerns and Health Concerns

Being healthy or being sick sometimes has to do with social conditions. Many of the "causes" of health problems are actually social problems. Poverty is probably the most important of these. It can lead to health problems such as malnutrition (being under-nourished or badly nourished) which can lead to a number of other diseases. In Canada poor and inadequate housing is a health hazard. Mental health problems are often created by life in our society. Stress plays a part in many physical and psychological health problems. When health problems are caused by social conditions such as inadequate housing, the only long-term solution is to change the social conditions.

When the bedroom meets the science lab

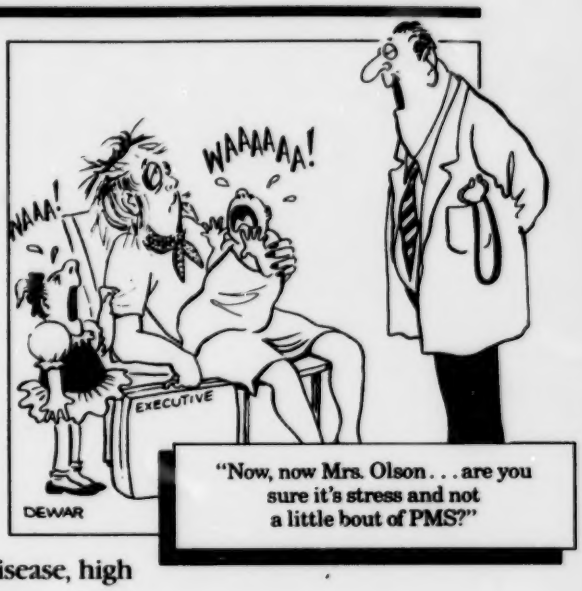
There are two types of reproductive technology. Those involved in the creation of new life are know as (1) artificial reproductive technologies and those involved in monitoring new life are known as (2) prenatal diagnostic techniques.

1. Artificial Reproductive Technologies are techniques which help women to become pregnant when they've had difficulty either through their own or their partner's infertility or the woman has decided to have a child without sexual relations. These techniques include artificial insemination, sperm banks, in vitro fertilization ("test tube babies"), surrogate motherhood, frozen embryos and surrogate embryo transfers. Many of these technologies are new. The medical profession's ability to dramatically change the "facts of life" raises questions about our definition of motherhood, the meaning and importance of being a biological mother, and the rights of women to the children born from their wombs. For example, the famous case in the United States of Baby M where a surrogate mother wanted to keep her child, raised many of these questions. The case also posed questions about the "father's" rights to the child born of his sperm.

2. Prenatal Diagnostic Techniques Prenatal diagnostic techniques are medical procedures that monitor the fetus. Amniocentesis and ultrasound are two examples. These procedures allow us to know some things about a fetus' health long before a baby is born. A woman may find herself in the emotionally difficult situation of knowing her baby may be born with certain abnormalities or disease. Understanding and coping with this information and deciding whether to continue or terminate the pregnancy can be traumatic considerations.

Women's groups are recognizing the need to think carefully about these technologies. As this is being written, the Ontario Advisory Council on Women's Issues is researching the subject of reproductive technology and a paper will be available to the public upon completion.

Stress



Stress is a major health problem for Canadian women (Clement 1987:7). Everyone experiences stress, but some women have more stress than they can handle. This may be because many women have two jobs: one for pay and the other as a homemaker and/or mother. Stress affects women's health in many ways. If we already have some illness, stress will probably make it worse. It also seems to have a major effect on such illnesses as heart disease, high blood pressure and some mental health disorders. It may also contribute to alcoholism, tobacco addiction, and drug abuse. As well, the very fact of being "disadvantaged" (that is, having less opportunity than others) causes stress by making day to day life more difficult. While more men than women are in mental and psychiatric hospitals and more men than women commit suicide (for 1981-2, Statistics Canada 1985:82-3), some studies have shown that women tend to be less happy and more prone to anxiety and depression than men. It seems as though women are more likely to be anxious and depressed regardless of whether they are employed, unemployed, or out of the labour force.

One study on psychiatric hospitals showed that more married than single women were likely to have psychiatric problems severe enough to require hospitalization while the reverse was true of men. Perhaps this is because of

Stress (continued)

the stress of a married woman's double role, working both inside and outside the home.

A doctor's opinion of whether or not someone is healthy usually reflects the doctor's view of what "healthy" is. Many women have argued that some experts think that being healthy for a woman means being "MORE submissive, excitable and emotional and LESS aggressive, independent, objective than a healthy man". (Health and Welfare Canada, 1978).

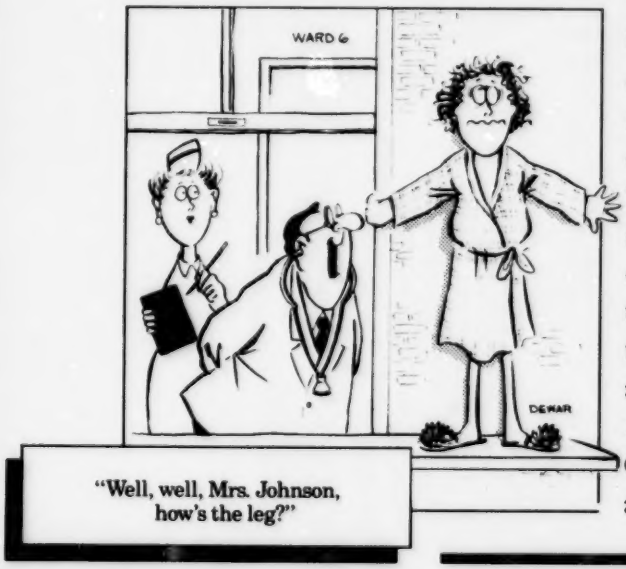
"A doctor's opinion of whether or not someone is healthy usually reflects the doctor's view of what 'healthy' is."

Sometimes women are unhappy due to the conditions of their lives. In such circumstances, being unhappy may be a reasonable reaction to the problems women face. Often trying to change the conditions that make women unhappy is more effective than treating the unhappiness with mood altering ("psychotropic") drugs such as Valium which a doctor may prescribe. All these kinds of drugs can be helpful in some extreme situations, but they can also make problems worse in the long run since they are addictive.

You can't always get what you want, but do you get what you need?: The Problem Of Access

In Ontario, we often say that patients have the right to make informed choices about their health care. But often these various alternatives are not available. Even women living in a city, surrounded by a variety of health care services, may have a hard time obtaining the services they need. Specific groups of women face varying problems in trying to get good health care. Some of these (like language problems) are barriers which the health care system can overcome fairly easily, by recognizing them, taking them into account, and providing extra services (like translation services) to make health care more accessible to everyone. Others are harder to correct, because they are part of the more subtle inequalities which exist in our society.

The personal prejudices of individuals working in the health care system can have a very real effect on the health care of the people they are supposed to help. For example, a doctor who believes women are likely to be hysterical (a stereotype that was very common not long ago) may tend to discount a woman's health complaints. The problems mentioned below represent some important gaps in our health care system. Tips on steps you can take to counteract, overcome or lobby on these issues can be found in parts three and four of this booklet.



"Well, well, Mrs. Johnson, how's the leg?"

1) Communication Problems

Can you imagine being sick in hospital and unable to talk to doctors, nurses,

or the other people around you? Although a number of Ontario hospitals try to provide services in both French and English, they aren't always available in both languages. Many immigrant and native women don't speak either official language well or at all. In some cases members of hospital cleaning staffs have been asked to translate for women about to have serious operations.

Sometimes, even when language isn't a problem, there are cultural barriers between a patient and the health care workers preventing the patient from getting the best possible care. A restrictive medical diet, for example, may be confusing for a woman who comes from a culture which is not familiar with the North American foods prescribed.

2) Disability

Eighteen percent of Canadian women are disabled. Disabled women are more likely than others to be victims of violence, sexual assault and poverty (Health and Welfare Canada 1987:11-12). Although they may have greater need for health care than most, they may also have greater problems getting good health care when devices to assist them are not available. The deaf or blind have a hard time obtaining and using information since the special needs of this group are rarely considered. People with other disabilities may find it physically difficult to get to the services they need.

3) Location

Physical isolation can be another barrier. All the best advice about looking for good doctors and learning about alternatives is useless if you live

ACCESS AND THE ABORTION ISSUE

Accessability is a big problem for many women's health services. One service that is relatively easy for some to obtain, but nearly impossible for others to get is abortion. Although it is recognized as a legal medical procedure, women from over half of Ontario's counties have to go outside their areas, at their own expense, to get an abortion.

Many of the access problems outlined in the main part of this booklet may play a part here: sometimes there are no qualified doctors in the area, sometimes qualified doctors will not perform the procedure, some hospitals will not permit abortions, hospitals in major cities that do perform abortions often have quotas for women from outside the area, and so on. These types of problems may cause long delays, and many women may be unable to get first trimester abortions. Second trimester abortions are far more dangerous than abortions performed earlier in a pregnancy (Powell 1987).

somewhere with only one doctor (or perhaps none) and no alternative kinds of care. Women who live in remote areas often have very few choices (see, for example, "Accessability and Abortion", highlighted above). On native reserves in northern Ontario, for example, there may be a nurse in the community, and a doctor (often young, inexperienced and unfamiliar) who comes up once every two months. Where no services are available, women in remote areas may have to travel great distances for medical attention. Travelling is expensive, time-consuming and inconvenient, taking patients far from family and friends. Patients have to accept medical care from doctors they have never seen before and may never see again.

Even when services are available, living in isolation can aggravate women's health problems by adding to the stresses and struggles of everyday life.

4) Older women

Older women may experience similar problems. A 1982 brief on Women and Aging published by the Ontario Advisory Council on Women's Issues showed that older women are generally poorer than men, and more often single. This poverty and isolation can create problems relating to poor nutrition, poor living conditions, and poor mental health. Many older women suffer from vitamin and mineral deficiencies because of inadequate diets. Problems can be aggravated by "ageism" (discrimination on the basis of age). Serious health problems like depression and alcoholism may be wrongly dismissed as senility (Dobbie 1978:4).

Older women may feel very vulnerable and, like the rest of us, may be intimidated or frightened, especially when sick. Many may be especially upset by hospitals. Often their experience of them is very limited. For many, the last time they were in hospital was four decades earlier, when they were giving birth. Older people are also likely to have the traditional reverence for doctors. It is only recently that patients have begun to realise that they can (and should) question doctors. But older women and men are often afraid to ask questions.

5) Prejudice

There are other people less likely to get good health care: poorer or less educated people may not be given as much respect as they deserve. Women of colour and lesbian women, may also experience prejudice within the health care system.

6) Poverty

In addition to the prejudice that poor women face, poverty itself is an important health hazard. Health care is only part of the health picture. We usually visit doctors and other health care workers after the fact, once we are already sick. The most important factor in the relatively poor health of native Canadians is related to economic conditions. In many cases, improving housing and water supply will have a bigger effect on a community's health than bringing in more doctors.

The Health Care System is More Than Just Doctors

Recently, there has been a lot of enthusiasm for the idea of expanding the health care system to include more different kinds of health workers. One of the main reasons for this trend is simple economics. The Canadian Nurses' Association says:

> We will always need the expertise of doctors and other health care professionals in the life-saving and life-supporting resources of hospitals, just as we will always require the special skills of nurses in hospitals. However, we must save these high-tech, high-cost services for those who really need them, and use our limited resources to offer more economical and efficient home – and community – based care. (CNA 1983)

Many people, and especially women, want to emphasise non-hospital health care for more philosophical reasons. They believe in a holistic approach to health, one which takes into account the physical, mental and emotional well-being of the whole person. The medical system is set up for crises and dramatic high technology "interventions". At the same time, people are becoming more aware of the many different factors affecting health. People are beginning to understand that feeling mentally and emotionally well is very important to feeling physically well. Women have traditionally supplied this kind of holistic care for their families.

The financial crises facing hospitals very often result in staff cutbacks. A smaller staff means less time and personal attention for patients. Personal emotional support is most likely to suffer when staff have too little time to do their job.

This means holistic care is harder to provide just when we are coming to understand its importance.

A major part of hospital care is provided by nurses, medical interns and medical residents who, far too often, are overworked and underpaid. Although these people often deliver very high quality care, their working conditions may explain why they are sometimes a little short of time, attention, and sympathy.

In addition to doctors, there is a variety of specialists in the health care system — nurses, chiropractors, physiotherapists and dieticians, for example. These professionals have a lot of knowledge about their areas, often even more than doctors. The services they provide are often fully or partially covered, by OHIP (the Ontario Health Insurance Plan). In some cases, it may be necessary to be referred by a doctor. Usually these people have more time for you and may seem less intimidating than doctors. Often doctors may not think of referring their patients to these other kinds of health care workers; you may have to ask your doctor about them or seek them out yourself.

Power in the Health Care System

In our society, doctors are very highly regarded. We respect the knowledge their years of rigorous training have given them. Partially because of this, we

> **"... we tend to put doctors on a pedestal. We literally trust them with our lives."**

tend to put doctors on a pedestal. We literally trust them with our lives. It is comforting to believe that doctors are infallible miracle workers. But they

aren't. It is important for us to try approaching doctors realistically. They do have a body of knowledge and expertise, but they are human, and they can, like anyone, make mistakes. This means that we can't expect them always to fix everything and to be perfect; it also means that we have the right to question them.

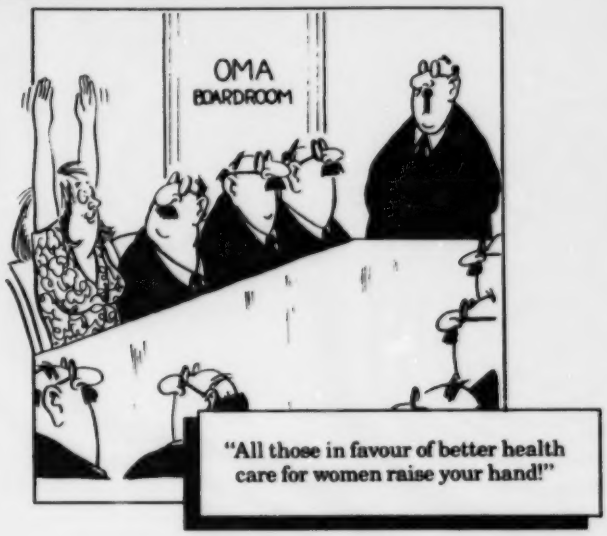
> **"Although most healthcare workers are women, the majority of doctors are men."**

Although more women than men work as health care providers, the ones in charge are usually men. It is important to emphasize that by tradition, women have been (and continue to be) the major health care providers for their families and patients, both inside and outside the home. Some believe that the work of doctors is overvalued, while nurses are not given enough credit for their essential, more continual care.

If income says anything about the roles women play in the health care system, then it shows that men working in medicine and health hold more of the prestigious (and high-paying) jobs. During 1981 Ontario women working in medicine and health earned an average of $11,744 a year while men earned an average of $34,427 a year in this field (Ontario Ministry of Treasury and Economics 1986:141).

Male doctors have always had more than their share of the profession's highest status jobs. This isn't just because it takes people a while to work up in their

career and women have come into medicine more recently. For example, the Ontario Medical Association has had only three women on its board in the last one hundred years.



Although most health care workers are women, the majority of doctors (who have the most authority) are men. Recently the number of female doctors is increasing. Forty-two per cent of those who passed the medical registration exams (that is, those entitled to call themselves doctors) in 1985 were women. Because these changes are very recent, the proportion of female doctors is increasing only gradually, but the long term outlook is promising (Ontario Medical Association 1987, table V). There will be more and more women doctors.

However, we cannot assume that women will gain equality within the medical profession just through the strength of numbers. Women doctors are facing barriers similar to those all working women face: the health care system is set up and run largely by men. It will need adjustments to accommodate women, with systems making it easy for women to drop out temporarily to have children, for example. One hopes that equality for women doctors will help to bring equality for all women.

If you are interested in a particular health problem for personal reasons or purely out of interest, you will want to do some research (see reference section for starting points). There are a lot of places you can go for information and there are many resources you can use, but it helps to know where to look, and how to approach the problem. Nothing can teach you how to do research like experience, but we will try to give you some pointers on how to find out about women's health issues. We use three examples, breast cancer, AIDS and birth control. The examples are specific, but the approach is general, and you should be able to apply it to other health problems.

Example One: Breast Cancer

Breast cancer is a major women's health problem. After lung cancer, it is the second highest kind of cancer for women. But breast cancer is also one of the most treatable forms of cancer. The fact that it is relatively easy to treat means:

1) that it is important to try to find it early through breast self examination and regular check-ups and,

2) that those who have it should give serious thought to the kind of treatment that is right for them.

It is no longer true that a woman with breast cancer must lose her breast. There are a lot of alternatives to be considered. A woman with breast cancer should do some research into the many types of treatment available. She might want to:

1) **Read up on options** like radical or partial mastectomy, lumpectomy, chemotherapy. (A few references on breast cancer and treatments can be found in the reference section of this booklet.)

2) **Talk to people who have had the various types of treatment.** You may ask doctors, counsellors or the Canadian

Cancer Society for names of other patients. You may also discover some sort of self-help group for breast cancer patients. The members of a group like this may share their experiences with you. Don't forget to bear in mind that no two people are likely to have exactly the same problem.

3) **Discuss your concerns** with, friends, family, medical personnel and/or advisors.

Example Two: AIDS

AIDS (Acquired Immune Deficiency Syndrome) is fast becoming the most complex and frightening disease of the decade. People understand more and more about AIDS every day, though many people remain ignorant about it. More and more groups have started to give out information and referrals to people with questions, and to support victims of the disease. If you are interested in AIDS, or any disease, there are two kinds of questions you may have: personal (on your behalf or someone else's) and educational. These two types of questions demand different types of research, and both are underlined below.

As a Personal Health Concern:

1) The first place you should go for any concern you might have about your own health is your **GP** (general practitioner) **or family doctor**. She/he knows you as a patient, knows your health background and medical history and is better qualified than anyone else to give you advice on your health.

2) If you don't have a GP, see if there's a **free health clinic** in your area. You may feel more comfortable in a women's clinic if there is one.

3) **How to find a clinic:** if you don't know where to find a

PART THREE 3

How to get active in women's health care

Get Involved!

Clearly, health is everyone's business. But if we are not careful, other people will make decisions and choices for us. We have to be particularly cautious because these others may have different goals. It is often easy to get apathetic and depressed about trying to change the way hospitals deal with us because they seem so enormous and impersonal. But there are ways that we, as individuals, can make a difference.

You can become involved in your own and your family's health care, taking a more active role, insisting on talking with health care workers and participating in making decisions. You can also become involved in the larger debates. Why not say how you feel about Ontario's health care system? Speak out, particularly if you have an issue that especially concerns you or your family. You are an Ontarian. You help pay for the health care system. It's your right to be involved!

Looking for Doctor Right

Women usually take care of their families' health. But at the same time, we are often intimidated by 'experts', especially when they are men.

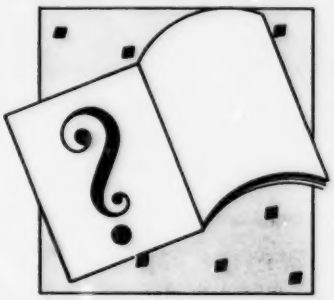
We must learn to ask questions and get answers, even though this may seem difficult at times. Sometimes a friend, possibly a nurse or pharmacist, can help you figure out what questions you need to ask. It is your doctor's job to explain any health problem, possible procedures, drugs, side effects, risks, etc. in a way

that you understand – make sure that you get as much explanation as you need. If you don't understand, it is NOT your fault. Ask again. Make sure you understand.

Going to the doctor can be intimidating. This is one reason some of us don't go as often as we should. But it is important to have a General Practitioner ("GP") for you and your family. She or he will know your medical history and you can develop a good, comfortable working relationship with your GP. This good relationship is very important. To get it, you may have to shop around a bit, but it will be worth the effort.

The Balancing Act: Their Technical Knowledge and Your Personal Knowledge

One of the most difficult things about this involved approach to health care is finding a balance between the technical knowledge of the medical people trying to help you, and your personal knowledge and feelings. Above all, it is important to remember that in the end, whatever other people may advise, any decision is yours to make, and you are the one who has to live with it.



Unfortunately, we can't believe everything we read. Things would be much simpler if we could. But it is important to remember that just because something is written down and published somewhere doesn't make it true. This doesn't mean we have to give up in despair, however. It does mean we have to learn to read critically, questioning the writer as we read.

Try posing questions like the following to material as you read:

- **Who is the author?** A group or organization? If it's an individual, what does he or she do? Is the author a professional writer, or some kind of expert? Remember that different kinds of experts have different assumptions and perspectives. For example, a surgeon may be more likely than other health care workers to argue for surgery as the solution to a medical problem.
- **Who paid for the research (if any) and who published the article or book?** For example, drug companies often fund medical research. This does not automatically invalidate any studies done with their money, but you should ask if the source of money might have affected the results.
- **What is the author's purpose in writing this document?** Why is he or she writing it? Is he or she trying to argue a certain political point? Is someone trying to sell something? Does the author have a particular axe to grind?
- **What are the author's underlying beliefs?** Look for the ideas that the author takes for granted. Are these reasonable beliefs and ideas? These may tell you a lot about the author's point of view and prejudices. They can also effect her/his conclusions.
- **Are the arguments well supported?** Some writers assert that things are true without supporting their arguments with facts. When this is the case, you should think of the authors'statements as opinions, rather than certainties.

4 PART FOUR

Organize!

Collective Action on Women's Health Issues

The other way that you can become involved in women's health issues is by organizing to express your opinions. If you have an issue about which you have strong ideas, try to find others who share your beliefs and see if you can change things. Many people have organized themselves into groups of various kinds, such as:

- support groups for patients, and people with a particular disease or health concern
- support groups for patients' families and friends
- lobby groups for improvement of services
- (in some cases) groups trying to prevent an illness
- public awareness groups (i.e. Canadian Mental Health Association)
- lobby groups of people whose health has been affected by something in the environment.

Some people tackle the larger social issues underlying many health problems. Many try to fight hunger, or address workers' rights, opposing workplace health hazards (such as anything from video display terminals, to dangerous chemicals, to smoking in the workplace).

First, check around by asking others to see if there is already a local group organized to address your issue. If so, join forces. Action groups can always use more energy, ideas and hands. If the group is small, just starting out or low profile, you may have to do a fair amount of digging to find it, but it is certainly

"Organizing my own women's health group is wonderful . . . I'm devoting all my time and energy towards finding out why I don't have any!"

worth the search. There is no point in wasting valuable time and energy repeating someone else's work. Ask around. Try the YW/MCA, the United Way, local women's groups, clinics, community information centres, local library, women's bookstore, schools or churches to see if anyone knows of people working on your issue (see reference section for some suggestions).

If you've looked, and can't find a group already in place, then it's time to start one of your own.

Steps to Organizing a Support or Advocacy Group

Here are some ideas on how to organize for collective action on women's health issues.

1) **Decide on a focus/aim.** Figure out exactly what you want your group to do. Try not to get carried away; pick a moderately small goal to start. You might begin with both long and short term goals. For example, you might want to start a support group, with longer term goals of raising public awareness of the health problem that concerns you.

2) **Get a core group of people together.** Usually a group needs a minimum number of people to get it started. It is probably best if you can start out with a group of people you know (and know you can count on!).

3) **Call a meeting.**

a) Time, date and location: You should be sure that the time and place are to the people you are trying to reach. If they are employed it should be outside of office hours, for example.

and, b) Advertise: In advertising the meeting, think about the kind of people you are trying to contact. If it is a support group, local specialists and hospitals may be able to spread the word to people in a similar position. If you are on a very limited budget, try to use as much free advertising as you can, for example: newspaper community calendars, public service T.V. and radio announcements, notices on bulletin boards. Talk to the local media and see if you can get a story about your issue and your group published. Don't forget local cable channels, community newspapers, etc. If your budget allows and it is appropriate, you may want to print flyers. Distribute them in hospitals, health clinics, supermarkets, laundromats, and other public places.

4) **Discuss your concerns and the goals of your group** at this meeting. This should help you focus your thinking, so that you can organize the group accordingly. If you are uncomfortable being the leader in this discussion, try to find someone who seems more comfortable doing it. For some groups, a written statement may help (although just because it is written down, doesn't make it carved in stone). A written document might also help if people want to know about your group.

5) **Think about how your group will be structured.** This will depend on the type of group. A support group may demand relatively little organization; it may just meet for coffee once a week. But you will probably still need to inform people about the group, book meeting space and handle refreshments. A lobby group, on the other hand, may work mostly in sub-committees, meeting primarily by phone. You may want to go for the usual president, vice-president, secretary, treasurer system, or you may want to work under a more co-operative model.

6) **Divide up responsibilities.** You don't want to be a one woman show so try to get others to take on tasks too. People are more reliable if they have specific responsibilities.

7) **If there are other groups similar to yours, in other towns or cities for example, recruit their help.** You can probably benefit from their experience. You might even invite a representative to join you at a meeting, to help get you started.

The DES story in Canada is one that went from a single woman's health concern to a national women's health group.

In 1981, when she was 20 years old, Harriet Simand discovered that she had cancer caused by DES (diethylstilbestrol), a drug her mother had taken to avoid miscarriage when she was pregnant with Harriet. Ms. Simand went to the United States for treatment where doctors were much more familiar with her illness.

Harriet Simand and her mother Shirley wanted to find out more about DES. They asked doctors and researched the drug, but found very little public information in Canada. Eventually, a friend mentioned a DES organization in Philadelphia.

"Take 30," a CBC television documentary series, featured a program on DES which included an interview with Harriet and her mother. With the airing of the show, and repeats across the country, the Simands began to receive letters from people all over Canada. They had been told that DES wasn't used much in Canada, but the drug had been on the market in Canada for thirty years, and estimates of the number of Canadian DES daughters and sons now lie between 200,000 and 400,000. Thus DES Action was born in the basement of Simand's Montreal house in 1982.

DES Action published information on DES, referred people to doctors who were familiar with the drug, and began a network of DES children. Interestingly, although sons could also be effected, most people who were involved were DES daughters, their mothers, and women's health activists. The media picked up the issue (Harriet recommends that you be prepared for a sudden onslaught of calls and letters resulting from media coverage!) and the group received a small government grant to pay for an office and a phone.

Today it remains an organization run almost exclusively by volunteers. There are now ten DES Action groups in Canada, with three in Ontario (Toronto, Ottawa, and the Northwestern Ontario Women's Health Information Network in Thunder Bay). The Montreal group has produced a start-up manual for new groups. In addition to giving out information and referrals, DES Action organizes support groups, and (although their focus is DES) fields some questions about other hormonal drugs and pregnancy issues. Although much of their lobbying is for funding, the groups also see lobbying on similar drugs as a logical extension of their experiences with DES.

The experience of Harriet Simand shows how a personal health concern can grow into a national organization. She had no previous organizational experience when she started. Since then, as president and founder of DES Action, she has spoken to many groups and been featured in a National Film Board film "D.E.S.: An Uncertain Legacy."

5 PART FIVE

Some concluding comments

In this booklet we have tried to show that we can have a say in Ontario's health care system. Health care is a shared concern and a shared responsibility. It is not just a biological concern but also a social issue with social causes and social consequences.

Many women want to see changes in the way we approach health and illness. Often the changes they advocate are concrete and practical. They often seem to be common sense and not at all "political" so we tend to think they will "just happen". But change hardly ever "just happens". Right now, the people making decisions about health care in this province are "experts" and politicians. And we can't afford to leave important decisions about the changing health care system to them alone. Knowledge and getting together with others to make your concerns known can be used to make the health care system work with and for us, to make it fairer and healthier. It is our firm belief that political action can bring services to people who need them and help change policy.

Therefore, we have outlined some steps we hope will help you become more active in health care and women's health issues. This booklet should be a jumping off point, and a beginning. The resources listed on page 43 will give you more places to look, and these, in turn, should provide further leads. So try to find out more and make a difference.

Glossary

Accessibility – The degree to which something or someplace can be reached. For example, accessibility is a problem for someone in a wheelchair approaching a building which doesn't have a wheelchair ramp.

Amniocentesis – A technique used to detect fetal abnormalities. A needle is inserted into the pregnant woman's uterus and a small amount of the amniotic fluid (fluid that surrounds the fetus) is withdrawn to be analyzed. Amniocentesis cannot be done until the 16th week of pregnancy.

Anesthetics – Drugs which temporarily deaden the body's nerves, thereby preventing pain.

Anorexia Nervosa – An eating disorder characterized by a drastic weight loss from too much dieting, sometimes combined with too much exercise. Although anoretics (people with anorexia nervosa) are often very thin (as little as 80 pounds), most don't recognize how thin they are and still "feel fat". It is more common in females than males.

Artificial Insemination is a procedure which allows a woman to become pregnant without sexual intercourse. Sperm obtained through masturbation is inserted into a woman's vaginal canal when she is ovulating.

Binge Eating – The eating of large amounts of food in a very limited time period.

Biological mother – The woman whose own egg produced a child.

Birthing Centre – Usually a free-standing building where a woman can go to give birth with a minimum of technical intervention. (In Ontario, the Ministry of Health currently funds only birthing centres which are located in hospitals.)

Bulimia – An eating disorder characterized by periods of uncontrollable eating followed by purging. Purging is done through self-induced vomiting, abuse of laxatives, or periods of fasting and is seen as a way to get rid of calories. Although bulimics (people with bulimia) may lose weight at first, they gain it all back due to the ineffectiveness of purging.

Chemotherapy – The use of drugs to treat diseases such as cancer.

Chiropractor – A qualified healthcare professional who treats the functioning of the nervous system by the adjustment or manipulation of the spinal column.

Dietician – A health care worker who specializes in proper nutrition.

Embryo – Human offspring in first eight weeks from conception.

Frozen embryos – Embryos, flushed from the womb or produced through in vitro fertilization, which are stored by being frozen.

Surrogate Embryo Transfers – see Surrogate Mother.

Fetus – A developing but yet unborn human.

General Practitioner (GP) – Doctor who practices medicine without any particular area of specialty. May also be known as the family doctor.

Genetic – Regarding heredity.

Gynecologist – A doctor who specializes in female reproductive health

Health promotion – The encouragement of a healthy lifestyle and healthier environments as a way of avoiding sickness.

Hormone – A natural substance produced by the body which stimulates certain organs and cells into action. Hormonal drugs are medications which cause the same action.

Hypochondriacs – People who are unnecessarily worried or anxious about their health.

In Vitro Fertilization (IVF) – A procedure which enables women with certain reproductive problems to bear children. An egg is surgically removed from one of the ovaries, fertilized in a glass dish with sperm from the male and replaced in the uterus. Babies conceived this way are also known as "test tube babies".

Lobbying – An act in which specific interest groups place pressure on those in power.

Lumpectomy – The removal of a lump from the breast without removing a large amount of breast tissue.

Malpractice – A doctor's improper or careless treatment of a patient.

Mastectomy – Removal of breast tissue due to the presence of a tumour.

Partial mastectomy: Only two or three centimetres of breast tissue is removed, leaving part of the breast.

Radical mastectomy: The entire breast is removed, along with the skin and underlying fat, the lymph nodes in the armpit and the major and minor chest muscles.

Midwife – A woman (other than a doctor) who is trained to assist women in giving birth.

Natural childbirth – To have a baby without the use of drugs or medical instruments.

Obstetrician – A doctor who specializes in all aspects of childbirth.

Physiotherapist – A professional person who specializes in the treatment of muscle injuries or deformities by using massage, heat or exercises.

Senility – Changes in mental behaviour usually associated with old age.

Sperm banks – A place where donated sperm are stored.

Sub-committee – A committee is a group of people who have come together to work on a project. A **sub-committee** is a smaller part of the same group working on a specific part of the project.

Surrogate Mother – A woman who has agreed (usually by means of a contract) to carry a child for others and is obliged to give up the child at birth.

Surrogate embryo transfers – The implantation of an embryo (taken from a woman capable of conceiving but unable to carry a child, or produced through in vitro fertilization) into a surrogate mother.

Trimester – A three month period. A nine month pregnancy is divided into three trimesters, the first trimester being the first three months, etc.

Ultrasound – A procedure in which high frequency sound waves produce the image of the fetus on a video screen.

Valium – A drug prescribed by doctors to calm the nerves.

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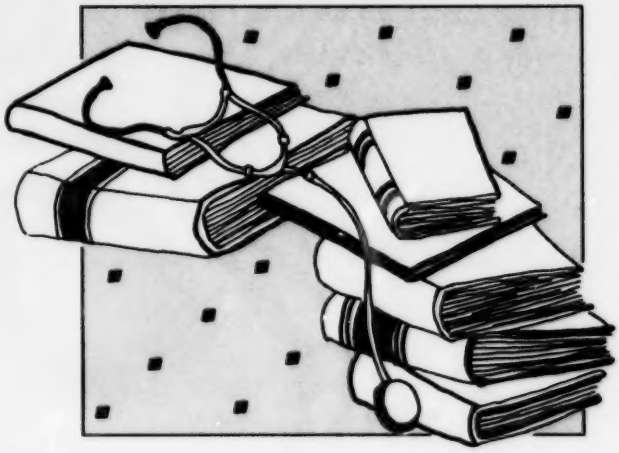

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Greaves, Lorraine and Margaret L.M. Buist
1986 **The Tobacco Industry: Weeding Women Out**. Broadside. Vol.7, No. 7, pp.8-10.
– has a feminist perspective, looking at the relation of power, powerlessness, and targets for smoking.

Health and Welfare Canada
1987 **Depending on Ourselves: Proceedings of the National Consultation on Women and Drugs**. Ottawa: Minister of National Health and Welfare.
– concentrates on four legal drugs commonly used by women
– alcohol, tranquilizers, antidepressants and tobacco

Jacobson, Bobbie
1983 **The Lady Killers: Why Women Smoke**. Montreal: Eden Press.

Rasmussen, Linda
1984 **Why Women Drink.** Healthsharing: A Canadian Women's Health Quarterly. Fall, 1984. pp. 9-12.

Rawson, Patricia, and Debbie Holmberg Schwartz
1984 **The Politics of Quitting Smoking.** HERizons: Women's News and Feminist Views. December, pp. 17-20. Manitoba, Alberta, R3L 0C8.
– contains useful tips on quitting smoking, and helping others quit.

c) Mental Health

Canadian Mental Health Association
1987 **Women and Mental Health in Canada: Strategies for Change**. Women and Mental Health Committee, Toronto.

Smith, Dorothy E. and Sara J. Davids, eds.
1979 **Women Look at Psychiatry: I'm Not Mad, I'm Angry**. Vancouver: Press Gang Publishers.

d) Food, Eating and Not Eating

An Introduction to Eating Disorders: The Facts on Anorexia Nervosa and Bulimia, distributed by the National Eating Disorder Information Centre, Toronto General Hospital, College Wing, 200 Elizabeth Street, 2-332, Toronto, Ontario M5G 2C4

Bennett, W.B. and J. Gurin
1982 **The Dieter's Dilemma: Eating Less and Weighing More**. New York: Basic Books.

Berland, T. and the editors of Consumer Guide
1983 **Rating the Diets**. New York: Signet Books.
– an honest appraisal of many diets, pills, clubs and books available for weight loss. A must for those who have been tempted by gimmicks and lost nothing but money.

Brody, Jane
1982 **Jane Brody's Nutrition Book**. Toronto, Bantam Books.
– a scientifically sound and practical book about diet and health, food and nutrition.

Chernin, Kim
1982 **The Obsession: Reflections on the Tyranny of Slenderness**. New York: Harper and Row.
– a feminist perspective on eating disorders.

Hope, J. and E. Bright-See
1982 **Every Woman's Book of Nutrition**. Toronto: McGraw-Hill Ryerson, Ltd.
– addresses the different nutritional needs and interests of women from adolescence through old age including her needs during pregnancy and the nutrition needs of her children.

Garner, D.M. and P.E. Garfinkel
1985 **Handbook for Psychotherapy for Anorexia Nervosa and Bulimia**. New York: Guilford Press.
– a technical and complicated, but complete book on anorexia nervosa and bulimia nervosa.

II **ORGANIZATIONS**

Canadian Advisory Council on the Status of Women
110 O'Connor St., 9th Floor, Ottawa, Ontario, K1P 5M9 (613) 992-4975

Canadian Council on Smoking & Health
725 Churchill Avenue, Ottawa, Ontario, K1L 5G7 (613) 722-3419

Canadian Mental Health Association, Ontario Division
56 Wellesley St. W., Suite 410, Toronto, Ontario, M5S 2S3 (416) 964-9611
– has 35 local branches which can refer you to groups in your area ranging from mutual support to vocational re-training. Contact the above address for local groups and for information and publications

CARAL, National (Canadian Abortion Rights Action League)
344 Bloor St. W., Suite 306, Toronto, Ontario, M5S 1W9 (416) 961-1507
– the major pro-choice group, contact this national group for local chapters.
– Childbirth by Choice Trust is the educational wing of CARAL. Literature and resource file available for public use. Provides speakers and audio-visual material.

The Disabled Women's Network (DAWN)
122 Galt Avenue, Toronto, Ontario, M4M 2Z3 (416) 694-8888

DES Action Canada
Snowdon, P.O. Box 233, Montreal, Quebec, H3X 3T4 (514) 482-3204

DES Action Northwestern Ontario
Women's Health and Info Network
8A N Cumberland St., Thunder Bay, Ontario, P7A 4L1 (807) 345-1410

DES Action Ottawa
Box 11091, Station H, Nepean, Ontario, K2H 7T8 (613) 829-9777

DES Action Toronto
60 Grosvenor St., Burton Hall, Rm 442, Toronto, Ontario, M5S 1B6 (416) 968-2844

Immigrant Women's Centre Inc.
750 Dundas St. W., Suite 301 Toronto, Ontario M6J 1T9 416-367-1388

National Action Committee on the Status of Women
344 Bloor St. W., Suite 505, Toronto, Ontario, M5S 1W9 (416) 922-3246
– a national umbrella organization for women's groups of all types. Also publishes a newsletter, Feminist Action, in both English and French, and has a health committee.

National Eating Disorder Information Centre
Toronto General Hospital, College Wing
200 Elizabeth St., 2-332, Toronto, Ontario, M5G 2C4 (416) 595-4156
– information on eating disorders in French and English, listing of eating disorder services across Canada, support groups, speakers, educational materials, and newsletters.

Northwestern Ontario Women's Health Information Network
8A N. Cumberland St., Thunder Bay, Ontario, P7A 4L1 (807) 345-1410

Ontario Advisory Council on Women's Issues
880 Bay St., 5th Floor, Toronto, Ontario, M7A 1N3 (416) 965-5824

Ontario Association of Adult Daughters of Alcoholics
194 Fern Avenue, Toronto, Ontario, M6R 1K4 (416) 763-2210

Ontario Public Education Panel on AIDS (OPEPA)
Public Health Branch, Ministry of Health 15 Overlea Blvd, 5th Floor, Toronto, Ontario, M4H 1A9 (416) 965-2168 1-800-268-6066
– information on AIDS, including fact sheets in seven languages, speakers referral service, films.

Ontario Women's Directorate (OWD)
48 University Ave., 2nd Floor, Toronto, Ontario, M5G 1V1 (416) 597-4500
– the women's issues ministry in the Ontario government. There are several branches within this ministry. Has information brochures, films, documents available to the public. Has a community grants program for projects benefitting women.

Planned Parenthood of Toronto
36B Prince Arthur Avenue, Toronto, Ontario, M5R 1A9 (416) 961-8290
– there are four other planned parenthood offices in Ontario; check your local phone book. Has information on family planning which it can send

out. Also has an in-house library. Can refer you to agencies in your area when you have questions on contraception.

Registered Nurses Association of Ontario (RNAO)
33 Price St., Toronto, Ontario, M4W 1Z2 (416) 923-3523

Toronto Women's Bookstore
73 Harbord St., Toronto, Ontario, M5S 1G4 (416) 922-8744
– A great resource for any books or magazines on women and women's issues. They will locate and order books specially for you at no extra charge.

Toronto Women's Health Network
c/o 0 L. Spring, 1884 Davenport Road, Toronto, Ontario M6N 4Y2
– an umbrella group representing over 100 groups and agencies; meets monthly and publishes monthly newsletter.

Women's College Hospital Health Education Resources
76 Grenville St., Toronto, Ontario, M5S 1B2 (416) 323-6030
– has many special health and health education programs for women.

Women's Health Interaction
58 Arthur St., Ottawa, Ontario, K1R 7B9 (613) 563-4801
– a national network of women. Focusses on family planning and population control, and on linking Canadian and third world women's health concerns. Also publishes a newsletter.

Women's Counselling, Referral and Education Centre (WCREC)
525 Bloor St. W., 2nd floor, Toronto, Ontario, M5S 1Y4 (416) 534-7501
– a feminist mental health service for women that provides: referrals to nonsexist therapists in Toronto and some out of town (including those who speak 14 languages). Also referrals to self-help groups, other community services.

Women Today
Box 1405 Clinton, Ontario N0M 1L0